1 had AIDS. No testing of cellular immunity was performed.
Conclusion: Age limits do not replace the serologic immune status of adults for measles. Up to a quarter of adults more than 40 years may be seronegative. Unless cellular immunity is not protecting from acquiring this highly contagious disease, these persons profited so far from the herd immunity in the society.

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Postsinusitis Staphylococcal Pituitary Abscess

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Objective: Single pituitary abscesses are in itself rare. A postsinusitis pituitary abscess by *Staphylococcus aureus* is a rarity too, since the germ is frequently found in non-operative sinusitis.
Case report: A 71 year old healthy man had been treated for frontal community-acquired sinusitis with cefutoxime during five days with consequent clinical amelioration but persistence of fatigue. Endocrinological exams revealed a panhypopituitarism. IRM examination of the sellar region showed a tumoral mass of $14 \times 9 \times 11$ mm size. There was no other suspect region either in radiological or in clinical examinations. Neurosurgical excision was performed in suspicion of a neoplasia, but the surgeons found franc pus. The culture identified methicillin-sensitive *S. aureus* (MSSA). Antibiotic treatment with intravenous Flucloxacillin 6×2 g/d during six weeks was successful.
Conclusion: Pituitary abscesses by MSSA and clinical late onset abscesses after "banal" episodes of sinusitis do exist (even by MSSA) and are difficult to be diagnosed. Literature is spearse. To our knowledge this would be the second case of *S. aureus* described in the literature. Further studies are needed to access the prevalence of this underreported, unusual, non-bacteremic origin in relation to classical postoperative abscesses by *S. aureus*.

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Leishmaniasis in Immunocompromised Patients: Shift in Risk Factors from HIV to Other Immunosuppressive Conditions. Retrospective Analysis of 12 Cases and Review of the Literature

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Introduction: Leishmaniasis is a rare disease in Western Europe. Migration can lead to emergence of cases in non-endemic regions. Underlying immunosuppression is a risk factor for severe course of infection. We were interested in frequency of disease in our area and risk factors for developing symptomatic disease.
Materials & Methods: We retrospectively analyzed all cases of leishmaniasis diagnosed and/or treated in our hospital and searched charts for underlying diseases and epidemiology.
Results: From 1990 to 2005 we found 12 cases diagnosed with leishmaniasis. 8 patients were diagnosed and treated in our hospital, 4 patients were treated in other hospitals situated nearby. The diagnosis of infection with leishmania spp was confirmed histologically in 11 patients. In 1 patient only a serology was done to confirm diagnosis. Polymerase chain reaction with identification of the leishmanial strain was available in 6 cases. 7 patients were originally from a country with endemic leishmaniasis (5 from Italy, 1 from Portugal and 1 from Turkey). 5 patients were Swiss and acquired disease during vacation in endemic countries (1 to South America, 3 to Italy and 1 to Malta). In 9 of 12 patients (75%) an immunosuppressive condition was found. 4 patients had AIDS with a CD4 cell count of less than 100/mm^3. 5 patients had other immunocompromising conditions (3 patients with a malignancy treated with chemo-/radiotherapy, 1 patient under treatment with steroids, 1 patient with diabetes). In 3 patients no immunosuppression was found. 3 of the 4 HIV-positive patients developed symptoms of invasive leishmaniasis before the introduction of highly active antiretroviral therapy (1990–1998). After the year 2000 only one patient was HIV-positive, whereas other tumors/immunosuppressant therapies were more common.

Conclusions: In non-endemic areas the association of clinical relevant leishmaniasis with immunosuppression is common. There is a shift in risk factors from HIV to other conditions with cellular immunodeficiency.

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Equal Amounts of Intracellular and Virion-enclosed *Hepatitis C Virus* RNA in Peripheral Blood Mononuclear Cells

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Background: Hepatitis C virus (HCV) replicating in peripheral blood mononuclear cells (PBMC) may represent an extrahepatic viral reservoir. Quantitation of HCV RNA with regard to its local distribution and longitudinal course may help to assess the largely unexplored viral dynamics in PBMC.
Methods: Differential extraction of cell-associated HCV RNA enclosed in virions was performed in parallel with extraction of total cellular HCV RNA. Quantification of HCV RNA of both polarities was achieved by highly strand-specific real-time PCR assays. Plasma and PBMC of 30 patients were sampled for cross-sectional and longitudinal analyses for up to 40 months.
Results: HCV RNA was detected only in PBMC of viremic patients. PBMC-associated HCV RNA was found at relatively stable quantities over time, incorporated in viral particles to a degree of 40% (96% CI: 34.5–46.2), and showed limited interdependency with plasma HCV RNA. Ratios of PBMC- to plasma viral loads showed significant patient specificity.
Conclusions: Our findings of a substantial contribution of intracellular HCV RNA to total PBMC-associated HCV RNA support a concept of low-level replication in this compartment. We did not find evidence for HCV persistence in PBMC beyond clearance of plasma viremia. Nevertheless levels of PBMC-associated and plasma HCV RNA appear to be regulated differentially.

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Comparison of the Management of the *Norovirus* Outbreak During Winter 2004/05 in 12 Large Swiss Hospitals

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Background: A total of 69 *Norovirus* outbreaks have been reported in winter 04/05. Although recommendations for the community have been published in 2005 by the Federal Office of Public Health, Switzerland has no national guidelines or detailed recommendations for management of nosocomial *Norovirus* outbreaks.
Objective: To investigate if the management of this *Norovirus* outbreak differed substantially between 13 randomly selected large Swiss hospitals.
Methods: Retrospective analysis of a 17-item questionnaire sent to all 5 university and 8 large cantonal hospitals.
Results: 12 answered the questionnaire. A maximum of 3–5 PCR-confirmed cases was sufficient for microbiological evidence of *Norovirus* in 11 of 12 hospitals. All hospitals had a surveillance system but only 3 differentiated between community-acquired and nosocomial cases. Hand hygiene was substantially promoted in 11 hospitals and 10 changed to a formulation with a higher concentration of alcohol. All hospitals pursued an internal information policy and 3 informed the community. Infected patients were "contact" isolated up to 48 h after the last symptoms in all hospitals and, when necessary, cohorting was applied in 6. Droplet precautions were additionally implemented in all hospitals in case of vomiting. All hospitals required that staff wear gowns and gloves in contact with patients and a mask in case of vomiting. In 1 hospital, standard masks were replaced by FFP2 masks and in 7, a mask was always worn when in contact with affected patients. Infected staff was asked to take sick leave, but in 4 hospitals a substantial number continued to work (often with a mask) due to lack of staff. In 2 hospitals, sick leave was less than 48 h after the last symptoms. In 7 hospitals, dedicated toilets for infected patients were attributed and sanitary facilities as well as surfaces and floors were disinfected several times daily by nursing aides and housekeeping staff. In 8 hospitals, the cleaning and disinfecting agents for surfaces and floors were changed. A separation of toilets could not be achieved in at least 1 hospital or was not necessary in 4 hospitals due to isolation.
Conclusion: Despite a lack of national guidelines and a possible selection bias, the management